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M e m o r a n d u m

To: Anthony Scarpelli, Administrator
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Date: November 2, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On September 14, 2011 the Operation Guardians team conducted a surprise inspection of Plott Nursing Home in Ontario. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. During the walk-through of the facility, it was noted that resident 11-02-01 was lying in bed in pain. Dr. Locatell, the Operation Guardians' Medical Consultant, reviewed the Medication Administration Record and noted that the resident's 6:00 a.m. MS Contin 15mg PO (by mouth) had not been given. This resident is on Hospice Care for liver cancer. Upon review of the *24 hour communication book* a note stated that the resident was "out of MS Contin and would not have the medication needed for the 6:00 AM dose." The note indicated that a licensed nurse (LN) had called hospice and was told that the medication would be sent today, September 14. There was also a note stating that the resident had a lot of open areas to her right and left buttocks that no one had reported. According to the book, the LN cleansed the open areas with Normal Saline and applied a hydrocolloid dressing (this dressing is only to be changed every 3 days or when displaced) to the open areas. The night LN requested that the day LN obtain a treatment order for what she had done and for her to notify the responsible party. Dr. Locatell and the OG Nurse Evaluator (NE) removed the dressing and looked at the open wounds which appeared to be at least Stage II and approximately 2 cm x 2 cm.

   Upon further review of the *MAR* (Medication Administration Record) the night LN had given a PRN (as needed) pain medication Oxycodone 5 mg at 12:30 AM and 5 AM. It did not appear from the *MAR* that the day shift nurse had given the PRN medication, but with review of the *Narcotic Control Sheet* it appeared that Oxycodone had been signed out by the day LN at 8:30 AM. The day LN was called to the nurses' station and interviewed. She stated that the MS Contin medication was first re-ordered on 9/12/11 by the Hospice Nurse and again on 9/13/11, when the medication did not arrive with the 9/13/11 medication delivery. It appeared that the last MS Contin was given at 6 PM on 9/13/11. The LN didn't notify the physician when it was evident that the MS Contin was not going to be available and no back up plan was put into place. At 9:15 AM, when the day LN was interviewed she stated that she had given the resident a PRN pain medication at 8:30 AM but she had not had time to return to the resident and determine if the medication was effective. The facility LN and the OG NE, returned to the resident's bedside

and observed the resident was restless and moaning in pain.

DON Ramsy was called to assist with the medication issue and the issue of new pressure areas being dressed without a physician order. The *Treatment Log* was reviewed and there was no evidence in it or in the *Nurses' Notes* that the wounds had been measured and assessed. The DON stated that the facility had the MS Contin in their emergency medication kit and was able to obtain the medication for administration.

The resident's feet were to be floated off the bed. Upon examination of the resident in bed by Dr. Locatell and the OG NE, both feet were encased in dressings and were lying on the bed. When the feet were picked up off the bed the left foot had bloody drainage though the dressing and onto the bed. The resident was on a static, plastic, pressure relief mattress. According to facility staff the resident had been on an alternating pressure mattress that stopped working and this mattress had been put on the resident's bed on 9/13/11. The DON was informed that the resident was in need of a better pressure relieving mattress because she continued to have skin breakdown with the current mattress.

2. It was noted in the *24 hour communication book* that resident 11-01-02 complained on September 5, 2011 of burning when he urinated. His medical chart was reviewed and the OG teamwas unable to find any documentation that nursing staff had followed up on the complaint. When the resident was interviewed he stated he still had burning on urination. The OG nurse reported the resident's complaint to the DON and the resident's physician was called and an order was received for a urinalysis. This was eleven days after the facility became aware of his condition.

During an interview with the resident he reported his wife also resided in the facility. He mentioned she resided in a room down the hall and wanted to introduce her to the OG team nurse. The OG nurse asked if it was his preference not to be in the same room with his wife. He said "no, he would like to reside in the same room as his wife," and added it was their 65th wedding anniversary. The resident reported that he had discussed changing rooms with the Social Services person and was told that there were no rooms available at the time. However, during the walk-through of the building it was noted there were several empty rooms and a few rooms with only one resident. The nurse discussed the issue with the husband and wife and both agreed that their wish was to be together.

A review of the Social Services notes did not indicate any discussion or plan to move the couple into the same room, and there was no documentation in either resident's chart. The Social Services Director was interviewed by the team and made aware of the situation and the fact that it was their wedding anniversary. She stated she must have forgotten to document her discussion with the residents in her notes about the room request. However, during the interview with the Social Services person she gave several versions of why the room change had not been made and why there was no action taken on her part to accommodate these residents.

3. The OG nurse inspected the coccyx area of Resident 11-02-03 while the treatment nurse was providing wound care. The wound being treated was described as a "healing Stage II with the skin now intact to the area." An occlusive dressing was still utilized by the facility to maintain skin integrity. During the treatment it was noted the resident had a **new area of skin**

breakdown to the right gluteal fold measuring approximately 1.0 cm x 0.5 cm. This new pressure ulcer had **NOT** received treatment or attention from the nursing staff. According to the Nurses Notes there was no indication the staff had reported the breakdown. This brings into question the quality of skin checks being performed by this facility. It was also noted the resident was not lying on a pressure relieving mattress. When the treatment nurse was questioned about the lack of a pressure relieving surface she replied "She was on one when I worked on Monday. I do not know why she would not be on one today." The resident's heels were noted to be red bilaterally and "mushy" to palpation. There was no indication the resident's heels were being floated off the surface of the bed as there were no additional pillows in the bed or at the resident's bedside. This issue was brought to the immediate attention of the DON who said she would obtain a pressure relieving mattress for the resident.

4. Review of the medical record for Resident 11-02-04 indicated he had a "new stage II pressure ulcer to his coccyx area." The resident was observed lying supine in his bed and appeared uncomfortable as he was shifting his hips around attempting to find a position of comfort. When asked by the OG nurse if he was having pain, he replied "Yes, down there on my lower back." The call light was illuminated and a request for pain medication was made by the OG nurse. The resident was observed lying on a bed overlay mattress which was not inflated. The OG nurse requested the assistance of the charge nurse to investigate why the bed was not inflated. It was discovered that the mattress's power source was not turned on. The DON was informed and the team nurse requested the resident's heels to be inspected as they were lying directly on the hard surface of the mattress. Upon inspection it was determined the resident had deep tissue injury to both heels as the heels had significant areas (approximately 4.0 cm x 3.0 cm) of burgundy discolored skin. These heel injuries were not mentioned in the resident's chart. Again, this brings into question the quality of skin checks being performed by this facility.

   It should be noted the resident's *Care Plan* listed "unavoidable pressure ulcers secondary to decreased mobility" as a problem. Although the facility knew of the resident's potential for skin breakdowns, it did not appear that they implemented the skin assessments and appropriate care required for this resident. Additionally, they were not even monitoring the mattress to assure that it was working. <u>The skin breakdown and deep tissue injuries were avoidable for this resident</u>.

5. Review of the medical record for Resident 11-02-05 indicated the resident was leaving the facility and going "out on a pass" with a friend. According to the ***Patient Aware of Diagnosis?*** Document signed by the resident's physician, he was not competent and not able to give informed consent regarding his medical/physical treatment. The document further indicated the physician considered it to be "medically contraindicated to fully inform the resident of his medical condition or rights as he was unable to comprehend the explanation of his medical condition and resident's right's information." The physician's orders were reviewed by the OG nurse and there was no order from the physician authorizing the resident to leave the facility on a pass. By allowing the resident to leave the facility without an order from the physician, the facility is jeopardizing this resident's health and safety and is not in compliance with the physician's orders for this resident.

6. Upon review of the *MAR* for dietary supplements it was noted that the LNs would initial when a supplement was given, but there was no documentation regarding how much of the supplement the resident consumed. Nor did the Daily Nurse's Notes clarify how well the supplements were

tolerated by residents. This was concerning as several residents that received supplements were losing weight.

7. Resident 11-02-06 told the team she did not receive her shower on the previous day-- which was her usual shower day. She complained of being cold, uncomfortable with stiffness and wanted to receive a warm shower. She stated her requests were often ignored. The DON was advised that the resident was requesting a shower, and had not been given a shower the day before. The DON became confrontational and intimidating to the resident and the team nurse again requested this resident be showered. The Narrative Nurse Assistant Notes were reviewed by the team nurse and there was no documentation the resident had refused showers in the month of September. It should also be noted the CNA did not complete the day shift documentation for the previous day (9/13/11) as all boxes on the form for that date were blank. This was brought to the attention of the DON. This resident, like many other residents, was very cold and very uncomfortable. She indicated she was in some pain from her arthritis (made worse by the cold), and the team nurse had to request that the resident be given something for her pain.

8. The medical records of Resident 11-02-07 were reviewed because of a prior complaint received. Apparently she was on a pureed diet but given a hot dog by staff at a facility BBQ. She required hospitalization due to choking on the hot dog. According to the facility investigation the resident stated that she **wasn't** given the hot dog but grabbed it herself. The resident's daughter agreed that her mother would be likely to grab the hot dog. Better monitoring of this resident should have occurred to prevent this life-threatening situation.

9. The medical record of Resident 11-02-08 was reviewed because of a complaint of abuse by a CNA and the facility's subsequent retaliation against him for the complaint. We learned the resident had since been discharged to a lower level of care and no documentation was available in the chart to support the complaint.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. Upon entering the facility, the bottom drawer of the medication cart at Nursing Station 1 was open and the licensed nurse reported the lock on the drawer was broken. She was reminded by the team nurse of her responsibility for medications as a licensed nurse and her obligation to report the broken equipment immediately.

2. The temperature in the facility was extremely cold. Many residents had several blankets and complained about the cold. Residents were observed with sweaters or jackets on while lying in bed. Many individuals stated that the facility was "always" too cold.

3. The facility states they have a "Skilled Nursing side" and a "Long Term Care side" of the facility. All the beds in the LTC side have the old crank style beds that do not allow the resident to raise or lower the bed. The "Skilled side" has been updated with newer electric style beds that can be used by the resident to raise and lower the head of the bed by themselves. When interviewed, the Administrator stated there was no plan to update the crank style beds for the LTC residents. The

crank style beds are not desirable because they require a resident relying upon a staff person to adjust the bed.

4. The door leading from the dining room out onto Fifth Street was open approximately six inches and there was no one in the room or outside to explain why the door was left open. The dining room leads directly to resident rooms and puts residents at risk. Open doors can also be an infection control issue.

5. A water bottle and crumpled paper towels were left in the kitchen area of the Activity Room located by the Administrator's office. The kitchen area was in need of deep cleaning including the cabinets, appliances and counter tops.

6. A bucket with a mop on wheels was stored in the front lobby. This is a safety hazard for the residents.

7. Residents' personal care items e.g. urinals, toothbrushes, and emesis basins in bathrooms and at bedsides had not been identified with the resident's name. This is an infection control issue.

8. Many of the facility Geri-chairs had clear plastic covering the arms. The plastic covering was torn with cracked and rough edges. Other chairs just had the pink vinyl covering that was worn away. A Geri-chair parked outside of Room 123 had exposed metal rods extending out from the arm rests. The condition of all this equipment has the potential to cause harm to the elderly residents' fragile skin.

9. Durable medical equipment including Geri-chairs and wheelchairs were noted to be filthy and required deep cleaning. This can be an infection control issue.

10. A wall shelf located in the television room was broken within the shelving unit and books had been displaced. This is a safety issue for the facility residents as the books could easily fall on a resident. The patio sliding door in the room was unable to be opened. The team nurse requested assistance from a staff person and she also could not open the door. This is a fire code violation and poses a safety hazard to residents.

11. The water pitcher in Room 108 A did not contain water. There was no indication the resident could not receive fluids. This compromises the resident's ability to remain hydrated and is a quality of care issue.

12. The refrigerator in the Medication Room at Nursing Station 1 contained an expired bottle of insulin. A medication box dated 6/13/11 with the name "Meza" was wet and soaked through the packaging. These are infection control issues.

13. Many of the resident rooms had fans in them. The fans were crusted in dust. Some were sitting on waste baskets and could easily fall on a resident.

14. During the walk-through of the facility the OG team noted numerous personal items in rooms marked with the residents name and "Do Not Steal."

15. An unsecured oxygen tank was noted in the oxygen room.

ADMINISTRATIVE OBSERVATIONS:

1. The team received a large number of complaints from residents regarding thefts occuring in the facility. Many of the residents expressed great sorrrow when reporting personal items such as blankets made by family members, trinkets, books and plants that disappeared while they were sleeping or taking a shower. It was disturbing to see the amount of notes at the residents' bedside left by family members to the staff, such as one that read "Please do not steal my Mother's lotions." The facility clearly has a theft problem and we were unable to ascertain from the staff or administrators their theft and loss policy. This is a serious and very disturbing issue for many residents, which needs to be addressed by facility management.

2. The team spoke to many residents that appeared to be afraid and depressed. In speaking to residents, the team was told several times, "Please, please do not tell them (meaning the facility staff) that I told you this." It appears there is a possibility that residents are being verbally harassed and intimidated by the facility staff.

STAFFING:

Based on the July and August 2011 records provided by the facility, staffing levels were above the 3.2 hours per resident day (hprd) on six days of the six days randomly reviewed

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Sherry Huntsinger NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 263-1407, or Peggy Osborn, at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
October 31, 2011

Plott Nursing Home
September 13, 2011

I. Summary

The care of sixteen current or former residents was reviewed. At the present time, residents are being avoidably harmed due to deficient nursing care in a number of aspects, including pressure ulcer prevention and treatment and others as described below. The facility appears to lack adequate nurse staffing and adequate supervision of nursing care relative to the size of the facility and acuity of the residents.

II. Pressure ulcer prevention and treatment

One current resident, Resident 3, was noted by the licensed nurse on the overnight shift ending the day of our inspection to have "new" skin breakdown. She had been informed by a certified nursing assistant of "bleeding" of the buttocks area. The nurse applied a hydrocolloid dressing to the wounds without a physician's order. We observed the wounds and photographed them; they were at least stage 2 and appeared to have been present for at least one full day. This resident was on an air mattress which was not an alternating-pressure type, whereas an alternating pressure air overlay is standard for residents like this one. The resident appeared to be in pain, and appeared not to have been repositioned for many hours at the time we observed her. Clearly there was inadequate care to prevent these wounds in Resident 3, as nursing staff had not been monitoring her skin and repositioning her regularly.

Two recently deceased residents were found to have acquired full-thickness pressure sores at the facility. Resident 11 had been admitted to the facility on 6/1/11 and was transferred to the hospital on 8/8/11. Hospital records contained in the nursing home chart show that Resident 11 had a stage 3 wound on the sacral area and an unstageable wound on the left heel, neither of which were present on admission to the nursing home. The record lacks evidence that this resident had received needed repositioning, skin care, and monitoring of the skin as required, and no medical conditions were present to suggest that either wound was unavoidable.

Resident 13 also acquired a full-thickness pressure ulcer, during the same time frame as Resident 11. He had been a long-term resident of the home, and experienced a decline in his functional status following surgical repair of a left humerus fracture for which he was hospitalized; he returned to the facility on 7/5/11. Upon return, a pre-existing wound on the left sacral area had "increased in size during hospital stay", but was superficial with

no measurable depth. Wound measurements remained static over the next month, but on 8/9/11 it was discovered to have more than doubled in size and was covered with necrotic tissue. An additional wound on the right sacral area occurred and also progressed to full-thickness after Resident 13's return from the hospital. By 8/19/11, the wounds appeared infected; 4 days later, the resident was transferred to the hospital with septic shock and died the same day. Resident 13's record shows that he was never placed on a specialty bed, and that he lost more than 20 lbs after returning from the hospital. The extent and severity of Resident 13's wounds was due to failures of care, as he also had no underlying medical conditions that made the worsening and infection unavoidable.

III. Nutrition and hydration

A current resident, Resident 5, had suffered recent weight loss and had laboratory tests taken 2 days before our inspection that indicated that she was dehydrated. Review of the record shows that the facility social services staff member had been informed by a nurse that Resident 5 was crying due to a painful tooth on 9/5/11, although no charting about this was found in the nursing notes. The staff person arranged for Resident 5 to be seen by a dentist; the dentist visited on 9/9 and recommended dental x-rays, but none had been obtained. The social services person told us that the dentist was going to prescribe antibiotics for Resident 5, but no order was found in the chart. The nursing notes do not reference the resident's tooth pain, dentist's visit, weight loss or the abnormal lab results. In fact, a nurse noted two days before our visit that the labs had been reported to the doctor but there had been no response, and no nursing follow up was documented. It is likely that the resident's weight loss was due to dental problems that had not been adequately assessed by nursing staff. The resident was dehydrated, with no action taken by nursing staff to address the abnormal laboratory results. The resident was receiving numerous supplements, with no monitoring of her consumption.

Resident 6 has also had recent weight loss. A registered dietitian visited on 8/29/11 but did not list the most recent weight taken on 8/24, which showed an additional loss of 2.5 lbs. The dietitian wrote that Resident 6 "refuses" breakfast and had "fair-good" appetite at lunch and dinner but did not comment on her consumption of supplements. In fact, this resident was also receiving numerous supplements, the consumption of which was also not being monitored by nursing staff. There was no analysis, by either nursing or the dietitian, regarding possible causes for the resident's weight loss.

IV. Antipsychotic drugs

In several of the cases reviewed, it appears that the facility is not adhering to generally accepted standards with respect to the administration of antipsychotic drugs. Resident 5 has been receiving the antipsychotic drug risperidone since 3/6/11 at a relatively high dose (0.5 mg twice daily) considering her age (92). This drug can have a number of adverse effects on older nursing home residents, included unintended weight loss. The stated reason for the drug was "paranoid behavior" and "yelling". There was no documentation to indicate what Resident 5's paranoid behavior was, other than yelling, and yelling is not an appropriate reason to administer an antipsychotic drug in a 92-year-

old nursing home resident. There was no indication that staff considered that the drug may have been contributing to her weight loss.

Resident 6, age 89, had been receiving olanzapine for "fighting staff during a.m. care" since 10/13/10. This antipsychotic drug is not indicated for behavioral disturbances in dementia, and review of the behavior monitoring record shows that she was having very few behaviors anyway. There is no indication that staff considered that the drug may have been contributing to Resident 6's weight loss either. In both of these cases, these drugs were unnecessary, exposed both residents to needless adverse outcomes, and likely did contribute to their weight loss.

Resident 9, on the other hand, did have a psychiatric illness, bipolar disorder, but was only receiving an antidepressant drug as of 9/2/11 when she returned from the hospital. However, on 9/7/11 she exhibited hostile, and aggressive behavior toward another resident (Resident 2), and in response her physician ordered the antipsychotic drug haloperidol via a telephone order on 9/8. Later that day, an increase in the dose and also a one time injection of haloperidol was ordered by telephone; the following day the haloperidol was discontinued and valproic acid was ordered, by telephone; later, another antipsychotic drug, ziprasidone, and an injection of haloperidol was ordered, by telephone; and on the morning of 9/10, she was transferred to a psychiatric hospital. There is no indication that the physician was requested to evaluate Resident 9, and there was no diagnosis made to justify the use of these drugs. The resident had the potential to harm herself and other residents due to her escalating behaviors, which clearly did not respond to the medications administered. There was also no indication that Resident 9 consented to the administration of the oral antipsychotics (one-time injections may be given without consent in an emergency situation), even though she was listed as being her own responsible party.

V. End of life care

The facility has a number of residents receiving hospice services, two of whom appeared to have inadequate pain management. In the case of Resident 4, it was noted in the 24-hour nursing report on the overnight shift prior to our inspection that her daughter was "very upset", apparently because she observed her mother in pain, and requested the nursing staff to give her morphine every 2 hours. Nursing staff had not been monitoring the resident's pain adequately.

In the case of Resident 3, as noted above, we observed the resident to be in significant pain the morning of our inspection. On review of her record and the 24-hour nursing report, it appears that there had been a significant delay in obtaining the morphine ordered for her from the pharmacy. Two days earlier, a request had been made for a refill, but as of the day prior, it had not arrived. The resident's last dose was administered the evening prior, leaving none for the morning of 9/14. The nurse on duty administered a dose of short-acting morphine instead, which potentially explains why we observed the resident to be in pain a few hours later. There is no justifiable reason for facility nurses to allow this resident to go without the long-acting morphine prescribed for her. There is

no indication that any nurse did anything to obtain the medication before the current supply was exhausted.

VI. Incontinence management

The facility uses cloth briefs rather than disposables. We saw indications that a number of residents' families had chosen to purchase disposable diapers that were then locked up in the medication room. In the case of Resident 3, we observed that she was wearing a disposable brief with her name written on it; it appeared to have not been changed for many hours, perhaps overnight. The practice of keeping the disposable diapers locked in the med rooms poses a barrier to adequate incontinence care, as busy CNAs have to find the nurse and get the diaper out of the med room before being able to provide the care. In questioning the administrator about this practice, he stated that it was the "family's choice" to purchase and provide their preferred type of undergarment. However, given the large numbers who are apparently choosing to do so, the stance seems unreasonable and likely to lead to poor incontinence management. The administrator had not queried residents or their families to find out why they did not wish to use the cloth briefs at no cost. In my experience, cloth briefs are more uncomfortable for residents and more difficult to apply and remove. The facility failed to provide what is best for the resident, regardless of the nominal increased cost for doing so, especially when incontinence care is as inadequate as appears to be the case at this nursing home.

VII. Nursing assessments and processes of care

Licensed nurses do not appear to be conducting adequate assessments, as noted in several of the cases described above. First of all, licensed vocational nurses may not conduct nursing assessments under their scope of practice; they may only make observations and gather data under the supervision of a registered nurse. There does not appear to be adequate registered nurse supervision at this nursing home. For example, there was only one registered nurse providing direct resident care on the day of our inspection. Review of resident records shows that the bulk of direct licensed nurse care is being done by LVNs. When LVNs cannot conduct nursing assessments, residents go without.

Resident 8 was due to be discharged after rehabilitation the day after he suffered a stroke at the facility. He was found at 4 am on 8/29/11 to have weakness on the right side of his body and difficulty speaking—cardinal signs of a stroke. The LVN on duty called the physician to report that Resident 8 "might be having a TIA [transient ischemic attack]"; the physician prescribed anti-platelet drugs. There was no subsequent monitoring of the resident's condition until after "changing of shifts", at which time he "was found to still have a neuro[logical] deficit" and so was transferred to the hospital. He did in fact have a stroke, and by the time he reached the hospital it was too late to administer a thrombolytic agent. Had the resident been assessed and monitored by a registered nurse, it is likely that the stroke would have been recognized, with the resident transferred to hospital timely.

In another example of poor assessment and monitoring, Resident 14 was noted to have complaints of burning on urination, according to an entry in the 24-hour nursing report several days prior to our inspection. However, review of the nursing notes in the resident's chart shows that there were no narrative entries referencing his complaints at all, and no assessment done. This resident has a history of urinary tract infection, and needed and deserved to have his complaints addressed. There was no follow up either, of the entry in the 24-hour nursing report.

The types of failures observed and described in this report suggest that nurse staffing is inadequate at the present time, in actual numbers, in training, in supervision, or a combination of these elements. There also appeared to be a lack of continuity of nursing care across shifts, another indicator in inadequate staffing. Considering the acuity of the residents, with many highly dependent, frequent hospitalizations, and other factors, the facility has failed to adequately maintain sufficient nursing services to provide the quality of care necessary for these residents.